HEALTH CARE ADVISORY BOARD

Meeting Summary
November 10, 2014

MEMBERS PRESENT
Bill Finerfrock, Vice Chairman
Rose Chu, Vice Chairman
Dave West
Dr. Tim Yarboro
Ellyn Crawford
Rosanne Rodilosso
Dr. Michael Trahos, DO
Francine Jupiter

STAFF
Sherryn Craig

GUESTS
Rosalyn Foroobar, Health Department
Arsenio DeGuzman, Health Department
Ebonye White, Molina Healthcare
Pam Cole, Health Department
Michelle Milgrim, Health Department
Joanna Hemmat, Health Department
Michael Forehand, Inova Health System

Call to Order
The meeting was called to order by Bill Finerfrock at 7:34 p.m.

October Meeting Summary
The October 15, 2014 minutes were approved as submitted.

Marlene Blum
Marlene Blum is recovering after becoming ill this weekend. She is doing well and will resume activities later in the week.

Community Health Care Network (CHCN) Electronic Medical Record (EMR)
CHCN/Molina EMR was recently upgraded in October to GE's Centricity Practice Solution (CPS) version 12 with new features and improved system performance. This initial upgrade (Phase 1) was completed to improve application efficiency and effectiveness. Many of the forms that CHCN staff use were not supported by GE.

CPS 12 makes it easier for CHCN clinics to meet meaningful use (MU) measures and clinical quality reporting. It is also designed to improve medical decision making by guiding and prompting providers through the medical decision making process.

Examples of Phase 1 improvements include:

- Enhanced source-cited clinical reference resources.
- If/when errors occur and there is a new feature, "Interaction Alert Icon", which means an error or temporary delay (that must be addressed) within the network or med database.
- Staff can now easily identify documents involving transitions of care via the transition of care documents and box selection.
- Two ways to classify medications: drug or non-drug. Previously, if an un-coded med was used it needed to be coded as a drug.

Four training sessions were organized to orient providers in using CPS 12. A decline in provider productivity has not resulted from the upgrade.

Molina owns GE Centricity EMR, but not the patient data. The cost for the October 2014 upgrade was absorbed by the existing Molina contract as part of the overhead allocation. If a new Request for Proposal (RFP) is made, the County would make certain stipulations around EMR operability and maintenance.

The new EMR has generated behavioral and outcome metrics that CHCN staff have been able to use in preparing grant requests.

Phase 2 improvements will include:

- New Medication Administration forms with additional features (e.g., user data-entry guidance, appearance of form and patient names in key locations, etc.)
- Mandated reviews on all e-prescriptions:
    - Users must now review and approve all prescriptions prior to sending them;
    - Providers can no longer sign notes without the prescription being approved;
    - No option to select all meds at once; and
    - If all meds have not been reviewed, the sign Rx button will remain in a flagged/incomplete status (i.e., greyed out).
- Improved recording of demographics:
    - Race: staff can now choose up to two races;
    - Can now manage and change custom race and ethnicity values;
    - Sub-categories link to main categories; and
    - A selection count next to race.
- Record new vitals forms: New form looks the same, but prohibits anything other than numeric values from being entered.

Going forward, there are additional EMR forms which will be added and removed based on clinical needs. Currently, the functionality of the upgrade is the same, but the look is different with regards to the navigation pane and tools. In addition, there are other external modifications (e.g., wireless improvements and desktop support) that Molina is implementing to ensure accessibility and minimize EMR interruptions.

Health Department Electronic Medical Record

Pam Cole, Infomatics Manager, provided a brief update on the selection of the Health Department's EMR. The Health Department has contracted with Netsmart, Inc. to implement a public health oriented EMR. It contains modules related to core public health functions such as communicable disease management, immunization, and epidemiology. It's expected to be up and running by next fall. The Health Department is currently in an analysis phase and working with its safety net partners and state/Health Information Exchange (HIE) to improve Netsmart's interconnectivity with other EMR platforms.

Ms. Cole agreed that there are significant costs associated with the HIE, including onboard fees to become a node on the network. Ms. Cole is aware that HHS is working to develop guidelines that would standardize EMRs to certify them for meaningful use.

With respect to EMRs tailored to the public health market, Ms. Cole said there are a few, but not many. Public health EMRs do not generate a lot of revenue. The main difference between non-public health and public health EMRs is the episodic nature of the activities. Netsmart has built-in modules that allow staff to manage TB, STD, immunization activities. The Health Department found that compared to other offerings, Netsmart was the most robust product.

The Health Department has used this vendor for 25 years and has no concerns about its financial viability. In addition to Netsmart, the vendor has a number of products around behavioral health and substance abuse. Netsmart is used by state and local health departments in approximately 20 states.

A comparison was made about federal guidelines around medical billing software, which operates more closely to a free market. In the EMR market, the vendor community knows that providers are under mandate to adopt MU standards, therefore, they are not as responsive to the marketplace as they would be if it were more competitive.

Nurse Family Partnership (NFP)

Joanna Hemmat, Assistant Director, Patient Care Services, briefed the HCAB on the Nurse Family Partnership (NFP), a unique, evidence-based, community health program implemented in Fairfax County about 18 months ago.

Across the country, there are ½ million children born every year to first-time mothers from low-income households. NFP is an evidence-based program with more than 30 years of data that shows it works.

NFP is transformative, changing the lives of first-time, low-income mothers. Women in high-risk populations face enormous challenges – including poverty, a dangerous physical environment, isolation, being young and lacking education. NFP is unique in

that each mother is partnered with a registered nurse trained extensively in the NFP standards by the National Service Office. This unique relationship between nurse and mother begins early in the pregnancy and each mother receives ongoing visits that continue through her child's second birthday.

What is remarkable about nurses is that they establish a powerful relationship with each young mother that helps them transform their lives and connect with their children. NFP has shown that young mothers who work with a nurse will do better in school, improve their economic well-being and become an active and involved parent who is present for their children.

Independent research shows that every dollar invested in Nurse-Family Partnership can yield as much as $6.20 dollars in return and societal benefits of $53,090 per family served. The Rand Corporation found that savings accrue in areas such as health care delivery, child protection, education, criminal justice, mental health and welfare and public assistance. Communities also realize a benefit through increased taxes and economic productivity generated by employed parents.

The Nurse-Family Partnership has had tremendous growth since it began in 1977. The mission of the National Service Office, founded in 2003, is to replicate the program in communities across the country. As of March 2014, Nurse-Family Partnership programs are in 43 states, the U.S. Virgin Islands and in more than 536 counties, three of them in Virginia.

The Nurse-Family Partnership is a disciplined program. Every nurse receives extensive training to ensure that they focus on three goals:

- Improve pregnancy outcomes: Help women practice sound health-related behaviors, including obtaining good prenatal care from their healthcare provider, improving their diet, and reducing personal health behaviors that can affect a child such as the use of cigarettes, alcohol and illegal drugs.
- Improve the child's health and development: Help parents provide responsible and competent care for their children.
- Improve families' economic self-sufficiency: Help parents develop a vision for their own future, plan future pregnancies, continue their education and find jobs.

During the first 30 months of a child's life – the period in which Nurse-Family Partnership works with its clients – basic functions related to vision, hearing, and language develop, and it is during this time period that trained registered nurses can have a huge impact on both mother and child.

Women can enroll in Nurse-Family Partnership as early in their pregnancy as they wish, but no later than their 28th week. By starting early in pregnancy, the nurse has time to

develop a strong relationship with the mother and has time to work on improving the mother's own health, and therefore the health of the newborn.

The program is intense – with up to 64 visits over the course of 30 months. Planned visits include: 14 visits during pregnancy, 28 visits during infancy, and 22 visits during toddlerhood.

Each nurse carries a caseload of up to 25 active clients and visits those clients in their home on a regular schedule. Visits are intensive ranging from weekly in the beginning while the relationship is being established and ultimately being held on a monthly basis. NFP is a rigorous program that requires intensive supervision and extensive collection of information by the nurse which is fed into a database to the NSO. It can be used by the Supervisor to monitor the nursing practice and assures consistency and fidelity to the model elements.

Services include assessments, screenings, weighing and measuring the infant, case management, education and guidance, all couched within the existing scope of practice and medical expertise that RNs bring to the table.

Nurses deliver individualized client care across the 6 domains. Beginning visits establish the relationship, rapport, and trust. The nurse focuses on health status, social, emotional, and economic context of client's life. The RN adheres to NFP guidelines, but constantly assesses for client's needs and strengths. Nurse home visitors also use professional nursing judgment to adapt to client's individual circumstances. Life course development focuses on the mother's future, and nurses also help their clients navigate the health and human services system to take advantage of resources that can benefit both mother and child.

Based on national data, NFP has resulted in important short and long-term outcomes.

Short-Term Outcomes include:

- Reduced hypertensive disorders during pregnancy
- Fewer cases of pre-eclampsia or pregnancy complications
- Fewer pre-term births
- Longer birth intervals (reduction in unplanned, closely-spaced pregnancies is extremely important in reducing risks for other negative outcomes, such as child maltreatment and injuries, and to move out of poverty.

Near-Term Outcomes include:

- Fewer childhood injuries
- 56% reduction in ER visits for accidents and poisonous ingestions
- Less days hospitalized in the first two years of life
- 48% reduction in child abuse & neglect cases
- 50% less language delays (better language development at age 4)

- Improved readiness to start school at Kindergarten.

Longitudinal studies have shown:
- Improved participation in the workforce
- Reduced (67%) behavioral/cognitive problems by six years of age
- 59% fewer arrests at age 15

The FCHD has been successful so far in the implementation of NFP, although it's still in the early stages (18 months since 1st NHV hired and 17 months since 1st client enrolled), which is largely due to strong agency and community support through the Community Advisory Board (Healthy Families Fairfax –NFP Home Visiting Advisory Council) as well as from the State (VDH) and NSO (monthly calls, webinars, site visits, etc).

There are three NFP Sites in VA all started with Maternal Infant Early Childhood Home Visiting (MIECHV) funding which was authorized by the federal Affordable Care Act (ACA) to respond to the diverse needs of young children and families living in communities at risk. Fairfax County's target population determined to be at risk live in the zip codes of Bailey's Crossroads/Annandale and Mt Vernon/South County areas. Through the implementation of NFP in Fairfax County, the Health Department has been able to enhance the continuum of home visiting services provided in the community. Prior to NFP, the County identified approximately 900 women/at-risk families who would have been eligible for home visiting, but could not receive them due to a lack of services.

A total of 118 women have been enrolled in the Fairfax NFP program since its inception (2013). Current program capacity is 90%. The median client household income is $10,500. The median client age is 24 years, and 65.8% of clients were unmarried at the time of program entry. Eighty-five percent are receiving WIC benefits. Most (96.8%) of NFP mothers initiated breast feeding, and 100% of infants are up to date with the appropriate immunizations. There have been no subsequent pregnancies at this time. As more clients age through the program, additional data will become available.

Ms. Hemmat will follow up on what controls NFP uses to test short, intermediate, and long term outcomes in addition to providing a chart that displays the continuum of MCH home visiting services.

Revised HCAB Work Plan

A revised work plan was distributed to HCAB members. Inova was scheduled to present its FY 2015 Fiscal Plan at the November meeting, but requested to be rescheduled for December 8. Moving forward, the annual fiscal update will be held at the December HCAB meeting rather than November. Previously scheduled items on chronic disease management and immunizations have now been moved to 2015.

Other Business

Update on George Mason University 50+ Trend Analysis Stakeholders Meeting. Marlene Blum, along with Health Department staff, attended a stakeholder meeting organized by George Mason University's College of Health and Human Services and in association with Fairfax County, to plan and implement a trend analysis of Fairfax County 50+ residents for the 50+ Community Action Plan. Along with service utilization, the HCAB identified the need to understand the cultural factors that drive LTC service demand. After attending the stakeholders' discussion, it appears that the HCAB will need to convene a separate panel to explore this issue. HCAB members agreed to plan for a separate presentation.

There being no further business, the meeting adjourned at 9:04 pm